The Pickering Report, Part I: why and how the study was established

With the introduction of medicare in Ontario, a revolutionary change took place in the role and relationships of the medical profession. Government's involvement in the delivery of medical service altered traditional patterns of practice and accountability to which it was often difficult for the physician and the public to adjust. Universal right to medical service without financial penalty solved some serious problems. It also and immediately caused others, for physicians, for patients and for government.

Almost two years ago it became clear to the board of the Ontario Medical Association, that some way would have to be found to clarify or redefine the role of the profession and its relations with the public and government. In May 1972 the association and its new president, Dr. L. R. Harnick, decided on the need for a study of this kind.

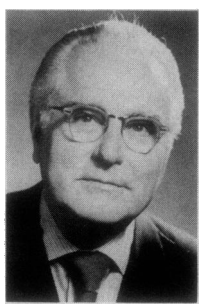
The OMA sensed a deterioration of its relationships with the public and patients on the one hand and with government on the other. It was obvious that the association would have to take the initiative if the erosion of confidence between the three parties — the profession, the public and government — was to be halted and reversed.

Largely on the advice and counsel of R. V. Hicks, Q.C. the special study was commissioned in June 1972. At that time, I was appointed to conduct the study using whatever resources I deemed necessary. The terms of reference were set by the Ontario Medical Association.

I was given a completely free hand to conduct the study in any way I saw fit and to bring in such recommendations as I in my sole judgement considered appropriate. I was also assured there would be no attempt, direct or indirect, on the part of the association to influence my conclusions.

All these assurances were most scrupulously observed in every respect by the Ontario Medical Association.

The terms of reference were illustrated and expanded in a series of speeches by senior officers of the OMA — by Dr. L. R. Harnick, president, Dr. Glenn Sawyer, general secretary and Dr. J. T. Colquhoun, immediate past-president.



Edward A. Pickering, retired industrialist, was commissioned last year by the Ontario Medical Association to do an independent study of the profession in that province and its relationships with government and the public. The $200,000 study, completed in May this year, has attracted national attention and many of its recommendations have been accepted, not only by the OMA but by other provincial divisions. Although CMAJ has already published (June 2, 1973) a summary of it, the editors believe Mr. Pickering's report of sufficient importance to be presented in its entirety to the membership of the Canadian Medical Association.

The following extracts are from a speech made by Dr. Harnick to the Rotary Club of Toronto, December 1972:

> The most novel aspect of this program, as one newspaper columnist has aptly pointed out, is that it is a study of doctors for doctors but not by doctors. It is a completely independent evaluation of the profession undertaken in the belief that a frank appraisal — with warts and all — will in the long run be beneficial to both the public and the medical fraternity.
>
> I firmly believe that as a profession we should not shrink from critical examination, nor should we fear to see ourselves as others see us. Undoubtedly, the OMA is striking out in a new and unknown direction by involving the public in what traditionally has not been a layman's area and by opening a door in our professional house that has hitherto been closed to the public.
>
> In one of our discussions with Bert Lawrence, when he was minister of health, he made the following statement: "We have a problem, the government and the profession, and we should have the wit to resolve it without confrontation."
>
> The public mood is no longer one of implicit faith in the medical profession, but of increasing criticism.
>
> Those who operate in the public realm . . . must expect to do so more openly and frankly in ways that demonstrate that the public's interest is not being overlooked or discounted.
>
> This is the background which led to the decision by the OMA last May to commission a completely independent study of the medical profession as it relates to society and government.
>
> As a profession, we expect to learn much from this study that is beneficial both to us and the public. We look:
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> • For a critical, rational and non-emotional examination of the profession by an acceptable public body;
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> • For a clearly-defined effort at public accountability;
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> • To emphasize the need for public dialogue and actively pursue it, so that we can obtain the public viewpoint and eliminate the distorted picture of the profession which has emerged because of lack of communication and mutual understanding;
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> • To demonstrate receptivity to change, and sensitivity to social problems by inviting outside participation into institutions once regarded as private preserves, as in the decisions regarding professional fees;
>
> • To avoid an adversary nature of

relations with the government and the public, and to indicate our desire to cooperate and consult in establishing policies that are in the best public interest.

These statements helped guide the direction of the study and the recommendations coming out of it. They are a clear call for change.

Terms of reference

The OMA's terms of reference for the study were to examine and report upon:

- The role of the medical profession in present day society viewed in the light of social change and economic factors;
- How the relationships between the profession and government within the province may best be furthered in the public interest;
- The relative economic position which physicians should occupy in society, taking into account their professional qualifications, the nature of their responsibilities, the extent and quality of the services they perform and the expenses which they incur in providing them;
- The method by which any modification in the physicians' fee schedule, indicated by this study may best be effected.

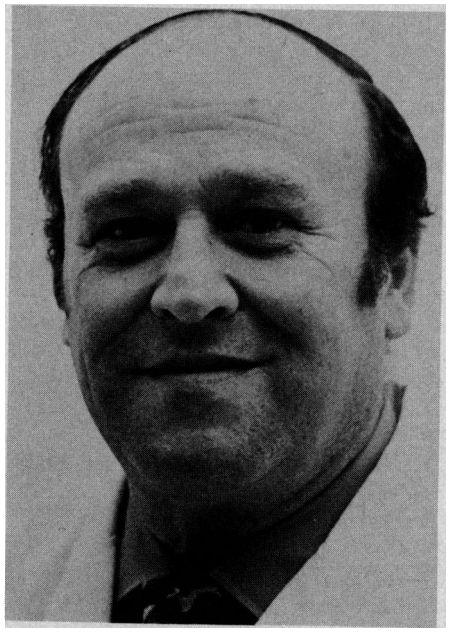
The exclusion of specific and narrow attention to medicare and of the general subject of the health care delivery system (in contrast to medical service offered by doctors in practice) was intentional. To have examined the overall health care system would have been beyond the capacity of this study and would have duplicated the work of the Hastings committee whose voluminous report was published a few weeks after this special study was announced. The effects of medicare on doctors, patients and government are implicit in the terms of reference and recur in this report.

The submissions and briefs did not, and perhaps could not, in all cases confine themselves rigidly to the terms of reference. But most of the submissions had, at least, an indirect relevance to the terms of reference and helped to complete the picture of public concern in the doctor-public relationship.

Research

The research conducted in the course of the study was extensive. Indeed it represents almost an embarrassment of riches. The basic message from all the research is unusually clear and the recommendations of this report are based on a careful analysis of it.

The association should consider making this basic material available for responsible further research in the future.



Harnick: public faith in MDs no longer implicit.

In addition to important papers by professors Ruderman and McCormack, discussed later, the separate elements of research were:

- Public hearings;
- Written submissions made directly to myself;
- An in-home opinion survey of a statistically valid sample of the Ontario population;
- A survey of a random sample of 50% of the membership of the OMA;
- The collection and tabulation of significant, published data on various aspects of the profession in Ontario, including comparative income levels, comparative doctor/patient ratios and operating costs;
- Personal interviews with selected representatives of the profession, the government service and the lay population;
- Selected reading of related reports prepared by others and/or in other jurisdictions.

The public opinion survey

The public hearings which were held during this study and the invitation for written submissions (204 were received) ensured the public could participate actively in the study.

But those who avail themselves of the opportunity of making a formal submission and of taking part in a public hearing are, by their very nature, an atypical sample. What they have to say, valuable as it may be, cannot be quantified; nor does it necessarily represent the views and concerns of the public as a whole.

Early in the planning stages of the study, it became evident it was essential that the general public of Ontario should have an opportunity to participate in the study. The profession, government and the study team should be able to hear what all the people — in contrast to some people — had to say.

It was, therefore, decided to invest a major portion of the study budget in a public opinion survey which would cut across socioeconomic and geographic lines in the province of Ontario; which would represent an accurate sample, as scientifically structured as possible, of the population as a whole.

The technical details of the survey's design and methodology (of interest especially to professional researchers) as well as the complete tabulations are included in the survey report. This report should be made available on request from the OMA for a reasonable fee to cover costs of reprinting, handling and mailing. It consists of over 130 pages.

For the general reader the following points should be made:

Those responsible for the planning and design of the survey were Terry Bird, director of research of Infocor Ltd., Montreal; Professor Thelma McCormack of York University; the very able and experienced director and staff of the survey research centre, institute of behavioural research, York University; and Michael Hicks of Price Waterhouse Associates.

The tabulations printed by the computer are cold data until interpreted and tabulations are often open to various interpretations, depending on the reader's point of view or bias. In the absence of comparative measurements from earlier surveys it is often difficult to interpret a statistic as being "good" or "bad". The problem is whether to look at the glass as being half-empty or half-full. Is it encouraging that two-thirds of the people are happy about a given situation, or is it unacceptable that one-third should be unhappy? On the whole interpretations are made from the latter position.

No research of this kind is perfect and it is virtually impossible to attach a definitive label to it. But this survey is as sound and objective as a number of professional people were able to make it, within certain inevitable constraints of time and money. The OMA was not consulted on the survey's design or content.

As far as can be established, little if any similar research has been conducted in Canada in the past. This is of considerable importance and should be underlined. For once, the public

at large has been consulted on the subject, not merely groups or individuals with special interests and special drives to make themselves heard.

What must also be underlined is that the survey represents an honest willingness, in spite of the obvious risks involved, on the part of the profession to hear what the public has to say. This, too, makes the survey unique. For, though the OMA had no influence over the research, it must live with the survey's findings. There are escape routes from submissions and public hearings. There is no escape from the tabulation of responses from a statistically valid sample of the province's population.

York's survey research centre, which conducted the survey, imposes one condition on users of its service: a survey and its tabulations remain stored in the institute's data bank and are available, after a suitable period, for the use of other researchers. Thus, the survey is, in effect, in the public domain and subject to scrutiny and verification by others.

One decision which restrictions of budget and time imposed was to exclude remote northern areas and those areas with 1000 population or less from the sample. It is recognized that the people in these areas probably have the greatest problems in obtaining service from the medical system.

Interviews were conducted by 53 specially trained interviewers in 779 homes with individuals 18 or over. The sample matches the socioeconomic and geographic profile of the province. A sample of this size is often considered large enough for national purposes. In this case it was confined to the province.

The first draft questionnaire was based on matters of interest expressed in six group interviews. These were conducted in Toronto, London, Tottenham and Ottawa and were designed to obtain opinions from people 55 or older; from the lower socioeconomic segment; from middle and lower-middle class people; from rural/small-town people; and from French-speaking men and women. The group interviews were loosely structured; participants were simply encouraged to talk about medicine, the profession and the medical system. The conversations were recorded and transcribed.

In addition to the questions which came out of these group interviews, additional questions were added to the final questionnaire by the research team. It must be remembered that no research of this kind can be exhaustive. There is a limit to the time which can be allowed for each interview. The person interviewed is only willing to give so much time (in this case about an hour for each interview) and, even if unlimited time were available, the cost of extending the length of each interview with more questions becomes uneconomic.

Findings

The findings of the study come under nine broad headings:

- Availability of physicians' services;
- Public expectations of physicians;
- Public behaviour in regard to medical services;
- Performance of physicians;
- The social significance of physicians;
- Physicians' incomes and cost of services;
- Government involvement;
- Future developments in medical services;
- Other opinions resulting from open-ended questions.

What follows is a broad discussion of the key findings of the survey report. In most cases the opinion of the total sample is quoted for the sake of brevity. But it should be kept in mind that significant differences of opinion sometimes occur between sexes, income and educational levels, geographical location, age and ethnic origin.

"..the physician's place in society, the strength or vulnerability of his position is at stake."

Availability of service

There has been considerable discussion, supported by all kinds of statistics, on whether there are enough doctors in the province. This discussion has rarely, if ever, been based on the consumer's feelings on the subject. His feelings are not good.

When over half (54.7%) of the people say that there are not enough doctors in their communities; and when, more specifically, almost two-thirds of the people (60.2%) feel that there are not enough general practitioners in their communities, government should take note.

This majority feeling that there are not enough doctors, and especially not enough general practitioners, points up the serious gap between the way people feel about a doctor shortage and the statistics on the subject.

While 91% of the population feel that "OHIP has been a very good thing" a very high proportion also expresses concern about the availability of medical service.

Only half (50.1%) of the people are confident of getting a doctor in an emergency situation.

Almost a third (29.7%) of the people feel their doctors' offices are not located conveniently enough.

One-fifth (20.7%) are not confident that having phoned their doctors, they will be able to contact them the same day.

30.5% of respondents feel that appointments must be made too far in advance.

As far as the customer is concerned the system seems to be overloaded. The system is not as available as it was intended to be and this is especially true as income and size of community decrease.

If a similar survey had been conducted before the introduction of medicare it would, of course, be possible to establish whether the present situation is an improvement. But in absolute terms, if one of the objectives of medicare was to create universal confidence in the ready availability of medical service, then there is grave doubt as to whether that objective has been achieved. Knowing that you are not going to be financially penalized for availing yourself of medical service is one thing. Wondering whether the service will be available when you need it is another.

This possible overloading of the system which many submissions have dwelt on, must have far-reaching effects on service, respect for the profession, even quality of medical attention. Since the medical schools and government, in the final analysis, decide how many doctors our medical schools produce, the subject of availability of service is one to which they should give serious attention.

Doctor-patient relationship

One of the more disturbing findings of the survey is what appears to be an erosion of respect for and trust in doctors.

The doctor is rated highest in importance to society over (in this order) the farmer, the religious leader, the member of parliament, the high school principal, the lawyer, the university professor and the bank manager. It is accepted that the doctor requires the longest period of training, though people do not necessarily relate training to importance.

When asked whether public respect for doctors is growing today, people were about evenly divided — 47.6% agreed, 46.0% disagreed and 6.3% not sure.

Similarly, when asked whether people generally trust doctors more today than they did in the past, 57.0% agreed, 37.4% disagreed and 5.5% were ambivalent.

There are some semantic problems here. Accurate interpretation depends on knowing what people mean by "trust" and by "respect". But it is not unreasonable to define trust as confidence in the ability to deal effectively with health problems, and respect as more of an interpersonal relationship factor. More people see trust increasing than respect, and this does suggest a decline in the doctor's image. This is to some extent borne out by other findings, as well as by the public hearings. That less than half of the people agree respect is growing must be of great concern to the profession. That over one-third do not feel that doctors are trusted more is also worrying. For, surely, the physician's place in society, the strength or vulnerability of his position is at stake. What is strongly required is for the profession to decide what steps should be taken to reinforce the trust and regain the respect of the public.

One of the most significant findings of the survey and one which the profession cannot ignore in its approach to improving relations with the public is that the single most important quality for which people look in a doctor is good human relations.

Service	**17.8%**
Competence	**34.0%**
Good Human Relations	**46.4%**
Other	**1.8%**

In a service industry it is not unreasonable to equate service with human relations. If a doctor does not return a call, if it takes too long to get an appointment, or if a patient must spend too much time in a waiting room, both service and human relations are poor. On this basis 64.2% of people can be said to be concerned with other than purely medical considerations in their assessment of professional usefulness. This reflects a strong consumer point of view and/or that the traditional doctor-patient relationship is being unrealistically oversold. Mere competence is perhaps taken for granted and is not enough. Quality of service, of responsiveness, is of overriding importance. Indeed, among those who were generally dissatisfied with their medical care (9.1%), more than three-quarters cited service and good human relations as key fac-

tors in the selection of a doctor. It is significant that only 22.2% of the dissatisfied cited competence as a factor compared with 34.0% of the total sample.

The other supporting side of this coin is that when asked for their one most serious complaint about doctors 38.1% cited poor service and 24.5% poor human relations. Asked for their next most serious complaint, 21.5% named service and 12.7% human relations. Seven and a half per cent named competence for the first question and 7.2% named competence for the second; 22.5% had no complaints.

Specific areas of complaint deserve careful attention from the profession, though they may not be surprising.

The problem of housecalls is an important one though the public is not unreasonable about this aspect of service (78.9% of the respondents feel doctors should be paid more for housecalls than for office visits).

Of the total sample 36.6% say their doctor is unwilling to make housecalls and this is the most frequent complaint of those criticizing medical service. More disturbing, perhaps, is that over one-quarter (26.3%) of people with complaints about service are concerned with the fact that doctors are not available when needed.

In the area of appointments 16.2% feel that doctors won't keep appointments on time and 14.5% feel appointments are hard to make.

Nearly one-third (30.6%) of the sample felt that their doctors did not give them enough time in the office and this was the principal complaint (52.6%) about doctors' relations with their patients. Indeed 29.3% of the sample categorize the physician as being, in various degrees, too busy, disinterested, impatient, aloof and uncommunicative.

In the area of competence, 13.1% of the total sample stated their doctor had been wrong in diagnosing a problem of theirs. Of those with specific complaints about competence (11.6%) exactly one-third complained about poor diagnosis and treatment; 21.1% about lack of knowledge and skills; 21.9% about hurried and careless examinations; and 23.7% about such things as over-prescription of drugs. Indeed, 18.4% of the total sample believe their doctor prescribes pills without first making a careful diagnosis of the patient's problem.

Almost one-quarter (24.4%) of the people feel the practice of referring patients by a general practitioner to a specialist adds unnecessary expense. This is possibly an area in which the medical profession has failed, to some extent, to demonstrate to the public that referrals are a means of obtaining better medical care for patients rather than more money for physicians. This may be so. On the other hand the public hearings have indicated concern that a patient does not have direct access to a specialist when the patient has a clear idea of what specialty is required.

In this context over one-third (35.5%) of the respondents feel that a doctor's instructions should be tempered with the patient's own common sense.

"..this tendency for patients to think of medical services as being free works against the system.."

The picture which emerges from these data is that the doctor-patient relationship is not all it should be if the medical profession regards itself as a service industry. The technical competence of the practitioner is not seriously in question — 88.9% of respondents are either very satisfied (66.5%) or somewhat satisfied with the medical attention they receive.

But over three-quarters of the people have serious complaints about doctors, most of them about the service and human relations aspects of the medical business. Most people do not feel that respect for doctors is increasing. These are circumstances under which a company in a service industry, competing with others, would likely go out of business. At the same time other service industries have similar problems. Although the customer may always be right it is impossible to keep the customer 100% happy. There is always a trade-off between customer relations and operational realities. The question is, what level of satisfaction is realistically achievable?

The public has certain criteria by which it measures medical service. To a large extent these criteria are not being met. There seems, really, to be only two options. Either the profession must find ways of improving its service and human relations or the public must be persuaded to change its criteria, to accept inconvenience and impersonality as the price for high quality medical treatment within the existing system. It is hard to see how the latter option can be successfully implemented in a consumer-rights oriented society. On the other hand the former option cannot be implemented by the profession alone. Enlightened help will be required from both government and the public.

Public use of medical services

The survey raised the question of patient use of doctors' services. Almost two-thirds of the sample (61%) had seen a doctor up to 10 times in the last five years and 40% up to five times in the last five years. These people can hardly be accused of overuse. On the other hand 82.7% of the people agreed "too many people go to see doctors who don't really need to", and there is no significant difference in response from different subgroups of the sample.

This is an indication of public perception of overuse and may well represent an opportunity for government and the profession to educate the public towards reasonable use, and/or provide paramedical alternatives to use of a doctor's time. If the public is aware of overuse it may well be receptive to learning how it can make more reasonable use of the system, particularly since 39% of the sample also agreed "the portion of Ontario's tax dollar going into health insurance is too great".

The medicare system is as new to the public as it is to government and the profession. There is no reason to presume — rather, the contrary — that the public, with leadership from government and the profession, is not prepared to do its part in making the system work.

Incomes, costs

Of the total sample, 45.5% were able to estimate their doctor's annual income. Of these over half (56.6%) estimated the income to be between $25,000-$49,000. This fits the facts quite closely.

Over half the respondents (53.0%) feel that, in general, doctors earn about what they should, though 29.9% feel that doctors earn more than they should.

The most important thing about this section of the study is that the public appears to have a fairly open mind on the subject of physicians' remunerations.

For example 69.1% agreed that doctors' fees should increase at a rate comparable to income growth in other occupations.

Over half (53%) of the respondents do not think that doctors are too concerned about making money. Thirty-seven per cent think doctors are overly

money conscious and another 10% are ambivalent.

Incomes of respondents had no significant influence on opinions about levels of doctors' incomes or doctors' attitudes to money. Well-to-do or poor, over half the people agreed physicians' earnings are about right.

Almost a third of the people (31.2%) feel that doctors should work for government and be paid a salary. The latter opinion is most frequently held, by a considerable margin, by people with lower incomes and education and from non-English speaking backgrounds.

There is, understandably, a low level of knowledge about the cost of medical service — 75% of respondents did not know what their doctor's fee was for the last visit; 69% paid nothing directly for the visit. There appears to be an increase in doctors' billing OHIP directly and in full and a decline in the number of patients' paying the doctor.

As has been pointed out elsewhere, this tendency for patients to think of medical service as being "free" works against the system. Proper use of the system by both doctor and patient to some extent must depend on the patient's knowing what government and, indirectly, the patients are being charged for a given service and, incidentally, knowing whether a service charged for has in fact been rendered.

Future developments

Finally, the survey asked a number of questions which were intended to discover how receptive the public is to changes in the delivery of medical services. Response to the questions indicates that the public does not find change unacceptable. Rather the contrary. Each of the questions had a strong service or efficiency bias and the public appears to be overwhelmingly in favour of any steps which will improve service and efficiency. This is important for the profession and government to know as a basis for future planning:

- 86% of the people are in favour of group practices where two or more doctors work in private partnership;
- 95% are in favour of neighbourhood clinics or medical centres where doctors from several specialties work together in one building to provide a range of services.

There may be some confusion in the public's mind about the distinction between a group practice and a neighbourhood clinic. But there is no question that people are overwhelmingly in favour of a system which allows for one-stop service, where if one doctor is absent another can see the patient and where, presumably, records and files are centralized. This finding is strongly supported by a majority of the submissions made at the public hearings.

From a technological point of view, it is significant that only 18% of the sample had no opinion (were probably unfamiliar with the concept) about "computer-assisted diagnosis where computers are used to help identify problems associated with specific problems". Of those who had an opinion almost two-thirds (62%) thought the concept was a good one.

This is surprising, since people tend to be suspicious of computers. It is, therefore, fair to deduce that the public is up-to-date in its willingness to accept technological methods which will improve service and efficiency.

There is a tendency to presume that the public "is not ready". This presumption seems to be unfounded.

Similarly, 82% of the people think that "the use of paramedical personnel for handling minor problems and generally assisting doctors" is a good idea. This finding runs counter to the assumption made before the study, that people reject paramedical help and insist on seeing the doctor for even the most minor procedures. The public hearings, for their part, strongly indicated a need for greater use of paramedical help.

There is general agreement (93%) about the need for "neighbourhood doctors who live and work directly with the poor and in depressed areas". This response may be interpreted as showing almost universal concern about the socially and medically dispossessed; and awareness that there are those whom the medical system does not serve as well as others — though they have equal right to service.

It is almost universally felt (95%) women should have the same opportunity as men to become doctors.

The public hearings, the submissions and the public opinion survey are three different kinds of research. What is interesting is the degree to which in general, the views of individuals in 779 representative Ontario households have supported the views of those articulate and committed individuals who took the trouble to make submissions.

The public survey has made it possible to establish that the opinion expressed in submissions, though presented from one biased position or another, did for the most part reflect public opinion. Without the benchmark of a scientific and unbiased public survey it would have been impossible to assess the value of our other research or to put full credence on it.